

CHAPTER I: OVERVIEW OF AMBULANCE FEE SCHEDULE

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OBJECTIVE

This chapter provides an overview of the ambulance fee schedule. It also introduces terminology and concepts that will facilitate understanding of the detailed discussion in later chapters.

BACKGROUND

Current Payment System

Medicare program pays for ambulance services on a reasonable cost basis when furnished by a provider and on a reasonable charge basis when furnished by a supplier.

- **The term "provider" means all Medicare-participating institutional providers that submit claims for Medicare ambulance services: hospitals (including CAHs), SNFs, and HHAs.**
- **The term "supplier" means an entity that is independent of any provider.**

The Medicare program pays for ambulance services in two ways; reasonable cost basis when furnished by a provider and reasonable charge basis when furnished by a supplier. For purposes of this discussion, the term "provider" means all Medicare-participating institutional providers that submit claims for Medicare ambulance services; such as hospitals (including critical access hospitals (CAHs)), skilled nursing facilities (SNFs), and home health agencies (HHAs). The term "supplier" means an ambulance company that is independent of any provider. The reasonable charge methodology which is the basis of payment for ambulance services furnished by ambulance suppliers is determined by the lowest of the customary, prevailing, actual, or inflation indexed charge.

Following are the current billing methods for ambulance services:

- Method 1 is an all-inclusive charge that includes all services, supplies and mileage.
- Method 2 is a charge for a base rate that includes all services and supplies. Mileage is paid separately.
- Method 3 is a base rate that includes services and mileage. Supplies are paid separately
- Method 4 is separate charges for services, mileage, and supplies.

All providers currently bill Method 2.

The reasonable cost methodology has resulted in a wide variation of payment rates for the same service based on location. This payment methodology is administratively burdensome, requiring substantial recordkeeping for historical charge data. Over the past 20 years, Congress has been moving toward fee schedules and prospective payment systems for Medicare payment. The Balanced Budget Act of 1997 (BBA) mandated the establishment of a fee schedule for payment of ambulance services.

BBA

BBA-97 requires fee schedule for all ambulance services.

Section 4531 (b) (2) of the BBA added a new section 1834 (l) to the Social Security Act, which mandates implementation of a national fee schedule for ambulance services furnished as a benefit under Medicare Part B. This section requires that in establishing the fee schedule, CMS will:

- Establish mechanisms to control increases in expenditures for ambulance services under Part B of the Medicare program;
- Establish definitions for ambulance services that link payments to the type of services furnished;
- Consider appropriate regional and operational differences;
- Consider adjustments to payment rates to account for inflation and other relevant factors;
- Limit payment for ambulance covered services to the lower of actual billed charges or the ambulance fee schedule amount;
- Phase-in the fee schedule in an efficient and fair manner.

BBA required that total payments under the Ambulance fee schedule be budget neutral.

BBA provided that the ambulance fee schedule be established through the negotiated rulemaking process described in the Negotiated Rulemaking Act of 1990.

Negotiated Rulemaking Process

BBA provided that the ambulance fee schedule be established through the negotiated rulemaking process described in the Negotiated Rulemaking Act of 1990.

A committee chartered under the Federal Advisory Committee Act conducted negotiations. CMS used an impartial convener to identify interests that would be significantly affected by the proposed rule and the names of persons who were willing and qualified to represent those interests. The Negotiated Rulemaking Committee on the Medicare Ambulance Services Fee Schedule consisted of national representatives with interests that were likely to be significantly affected by the fee schedule. The committee recommendations were included in the proposed rule.

Proposed Rule

- **Published On 9/12/00**
- **60-Day Comment Period**

PROPOSED RULE

CMS published the proposed rule in the *Federal Register* on September 12, 2000. The proposed rule set forth requirements for the new ambulance fee schedule as required by BBA. CMS plans to implement the fee schedule effective for ambulance services provided on or after April 1, 2002.

Negotiated Rulemaking Committee's Recommendations

- Definitions and RVUs for each category of service.
- Emergency response adjustment factor.
- Payment adjustments to reflect geographical variations.
- Establishment of an overall structure of the fee schedule.
- A four-year payment transition period.

Other Items Included in Proposed Rule

- Separate payment for mileage and base rate.
- Updated coverage of ambulance services.
- Ambulance inflation factor
- Revised Physician Certification Requirements.
- Development of a conversion factor.
- Include the transportation cost and all items and services furnished with the ambulance service in the base rate.
- Mandatory assignment for all ambulance services.

- A five-year payment transition period.

BIPA

The following payment allowances for ambulance mileage are effective for services furnished on or after April 1, 2002.

Payment for Rural Ground Mileage

BIPA §221 requires higher payment for payment for additional rural ground miles. The ambulance fee schedule amounts for rural ambulance ground mileage are as follows:

- For rural miles 1-17 the rate will be 50% more than the urban ground mileage rate per mile;
- For rural miles 18-50, the rate will be 25% more than the urban ground mileage rate per mile; and
- Ground mileage greater than 50, remains at the urban mileage rate.

Payment for Rural Air Mileage Fee Schedule Amount

Rural air mileage remains 1.5 times the urban air mileage rate per mile for all rural air miles. This amount is obtained from the fee schedule file.

Program Memorandum AB-01-185

Program Memorandum (PM) AB-01-185, dated December 14, 2001 provides for implementation of the ambulance fee schedule. The PM includes an effective date of January 1, 2001 with a disclaimer that the final rule implementing the fee schedule had not been published. Since the fee schedule implementation was delayed, CMS has implemented all the provisions included in the PM except for the fee schedule, mandatory assignment for all claims and payment based on beneficiary's condition.

Program Memorandum AB-01-185

- Published on December 14, 2001
- Includes instructions implementing the ambulance fee schedule

The fee schedule is effective for claims with dates of service on or after April 1, 2002. Payment is based on the lower of the actual billed amount or the fee schedule amount

The fee schedule is effective for claims with dates of service on or after April 1, 2002. Ambulance services covered under Medicare will then be paid on the lower of the actual billed amount or the ambulance fee schedule amount. The fee schedule will be phased in over a five-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers. During the transition period, the provider payment rate will be based on a blend of the fee schedule and the provider's current billing method.

The fee schedule applies to all ambulance providers. This includes volunteer, municipal, private, independent, and institutional providers (for example, hospitals, critical access hospitals, skilled nursing facilities and home health agencies).

CATEGORIES OF AMBULANCE SERVICES WITH NEW DEFINITIONS

Ground Ambulance Services

There are seven categories of ground ambulance services and two categories of air ambulance services under the fee schedule. (Note: "ground" refers to both land and water transportation.)

a. **Basic Life Support (BLS)** - means transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State. For example, only in some States is an EMT-Basic permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

b. **Basic Life Support (BLS) - Emergency** - When medically necessary, the provision of BLS services, as specified above, in the context of an

emergency response. Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

c. **Advanced Life Support, Level 1 (ALS1)** - means transportation by ground ambulance vehicle, medically necessary supplies and services and an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

Advanced life support assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

Advanced life support intervention means a procedure that is, in accordance with State and local laws, beyond the scope of authority of an emergency medical technician-basic (EMT-Basic).

Advanced life support personnel means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualifications of the EMT-Intermediate and also, in accordance with State and local laws, as having enhanced skills that include being able to administer additional interventions and medications.

d. **Advanced Life Support, Level 1 (ALS1) - Emergency** - When medically necessary, the provision of ALS1 services, as specified above, in the

context of an emergency response. Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

e. **Advanced Life Support, Level 2 (ALS2)** - The Advanced Life Support, Level 2 category is:

1. Three or more different administrations of medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate), **or** transportation, medically necessary supplies and services, and
2. The provision of at least one of the following ALS procedures:
 - Manual defibrillation/cardioversion
 - Endotracheal intubation
 - Central venous line
 - Cardiac pacing
 - Chest decompression
 - Surgical airway
 - Intraosseous line.

f. **Specialty Care Transport (SCT)** - means interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

g. **Paramedic Intercept (PI)** - Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. No

mileage is paid for this benefit. For a description of these circumstances and services see PM B-99-12 dated March 1999 and PM B-00-01 dated January 2000, both are titled Paramedic Intercept Provisions of the BBA of 1997.

Air Ambulance Services

There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

a. **Fixed Wing Air Ambulance (FW)** - Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, (for example, heavy traffic), preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

b. **Rotary Wing Air Ambulance (RW)** - Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, (for example, heavy traffic), preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Changes Related to the Fee Schedule

- Payment will be calculated on a base rate plus a separate charge for mileage.
- Payment for items and services is included in the fee schedule amount. Such items and services include but are not limited to oxygen, drugs, extra attendants, and EKG testing – but only when such items and services are both medically necessary and covered by Medicare under the ambulance benefit. Method 3 and 4 billers may continue to bill separately for items and services during the transition.
- Eventual elimination of a separate payment for items and services furnished under the ambulance benefit.
- Medicare pays only for the category of service provided and then only when the service is medically necessary and relevant to beneficiary's condition.

OVERVIEW OF THE TRANSITION TO A FEE SCHEDULE

Transition Schedule

Payment under the fee schedule will be phased in over a five-year period. In the first year, the fee schedule amount will be 20% of the fee schedule. The remaining 80% of the allowed amount will be based on the provider's reasonable cost subject to the cost per trip limit described in PM A-98-2. The fee schedule amount will increase each calendar year as a percentage of the total allowed amount from Medicare until it reaches 100% in year 5. During the transition, the amount allowed for an ambulance service will be the lower of the submitted charge or a blended rate that consists of a percentage of the fee schedule and the provider's reasonable cost. The phase-in schedule is as follows:

	<u>Fee Schedule Percentage</u>	<u>Cost/Charge Percentage</u>
Year 1	20%	80%
Year 2	40	60
Year 3	60	40
Year 4	80	20
Year 5	100	0

The allowed amount is subject to any remaining unmet Part B deductible amount and Part B coinsurance requirements.

Calculating the Blended Rate During the Transition

For services furnished during the transition period, payment of ambulance services will be a blended rate that consists of a percentage of both a fee schedule and a provider's current reasonable cost.

For services furnished during the transition period, payment of ambulance services will be a blended rate that consists of a percentage of both a fee schedule and a provider's current reasonable cost.

Intermediaries must determine both an interim payment rate based on the reasonable cost for a service furnished by a provider and the fee schedule amount for the service, then apply the appropriate percentage to each such amount to derive a blended rate payment amount applicable to the service.

The following sections explain the items that are used to arrive at a fee schedule amount. The contractors' systems will do this automatically. These sections are presented to further your understanding of how the fee schedule amount is derived.

COMPONENTS OF THE AMBULANCE FEE SCHEDULE

Ground Ambulance Services

The fee schedule amount comprises:

- Conversion factor (CF) is a money amount that serves as a nationally uniform base rate for all ground ambulance services;
- A relative value unit (RVU) assigned to each category of ground ambulance service.
- A geographic adjustment factor (GAF) for each Ambulance fee schedule area (geographic practice cost index (GPCI)).
- A national mileage rate for loaded miles; and,
- A rural adjustment on loaded mileage for services furnished in a rural area.

Air Ambulance Services

For air ambulance services, the fee schedule amount includes:

- A national base rate for fixed wing and a nationally uniform base rate for rotary wing.

Components of the Ground Ambulance fee schedule

- Conversion Factor
- RVU
- GAF/GPCI
- Loaded Mileage Rate
- Rural Mileage Adjustment

Components of the Air Ambulance fee schedule

- Uniform Base Rate for fixed wing and rotary wing
- GAF/GPCI
- Uniform loaded mileage rate for each type of air service
- Rural Mileage Adjustment

- A geographic adjustment factor (GAF) for each Ambulance fee schedule area (GPCI).
- A national mileage rate for loaded miles for each type of air service; and,
- An adjustment to the base rate and mileage for services furnished in a rural area.

DESCRIPTION OF FEE SCHEDULE COMPONENTS

Ground Ambulance Services

**Conversion Factor in
Final Rule is \$170.54**

(1) Conversion Factor

The conversion factor (CF) is a money amount used to develop a base rate for each category of ground ambulance service. The CF will be updated as necessary by notice in the Federal Register. The CF included in the final rule is \$170.54.

The RVUs are as follows:

Service Level	RVU
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
ALS1- Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

The GAF for the ambulance fee schedule uses the non-facility practice expense of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences.

For ground ambulance services, the applicable GPCI is multiplied by 70% of the base rate.

(2) Relative Value Units (RVU)

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. An RVU expresses the constant multiplier for a particular type of service. An RVU of 1.00 is assigned to the BLS of ground service. Higher RVU values are assigned to the other types of ground ambulance services, which require more resources than BLS.

(3) Geographic Adjustment Factor (GAF)

The GAF is one of two factors used to address regional differences in the cost of furnishing ambulance services. The GAF for the Ambulance fee schedule uses the non-facility practice expense of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the Ambulance fee schedule are the same as those used for the physician fee schedule.

The point of pickup, i.e., location where the beneficiary was put into the ambulance establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the point of pickup establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70% of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to mileage.

(4) Mileage

The mileage rate for urban ground ambulance services is \$5.47 per loaded statute mile. Paramedic Intercept has no mileage payment.

The ambulance fee schedule provides a separate payment amount for mileage. The mileage rate for urban ground ambulance services is \$5.47 per loaded statute mile. Paramedic Intercept has no mileage payment.

(5) Adjustment for Mileage for Services Furnished in Rural Areas

Payment is increased for ambulance services that are furnished in rural areas. This accounts for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period. For ground ambulance services, the rural adjustment is a 50% increase in the mileage rate to \$8.21 per loaded mile for the first 17 miles, and a 25% increase in the mileage rate to \$6.84 for miles 18 through 50. Over 50 miles is paid at the urban ground rate.

The point of pickup is identified by the zip code and establishes whether a rural adjustment applies. The point of pickup for each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the zip code of the point of pickup establishes whether a rural adjustment applies to such second (or subsequent) transport.

For all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service zip code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith Modification."

CMS will furnish contractors with electronic files that identify a zip code as rural or urban.

There is no conversion factor or RVU applicable to air ambulance services.

Air Ambulance Services

(1) Base Rates

Each type of air ambulance service has a flat base rate. The base rate for a fixed wing ambulance service is \$2,314.51. The base rate for a rotary wing ambulance service is \$2,690.96. No conversion factor applies to air ambulance services. Air ambulance services have no RVUs.

(2) Geographic Adjustment Factor

The GAF, as described for ground ambulance services, is applied in the same manner to air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50% of each of the base rates for fixed wing and rotary wing aircraft.

The mileage rate for fixed wing ambulance services is \$6.57 per loaded statute mile flown. The mileage rate for rotary wing ambulance services is \$17.51 per loaded statute mile flown.

(3) Mileage

The fee schedule for air ambulance services provides a separate payment for mileage. The mileage rate for fixed wing ambulance services is \$6.57 per loaded statute mile. The mileage rate for rotary wing ambulance services is \$17.51 per loaded statute mile.

(4) Adjustment for Services Furnished in Rural Areas

Payment is increased for air ambulance services that are furnished in rural areas. For air ambulance services, the rural adjustment is an increase of 50% of the base rate and all mileage. The point of pickup determines if there is a rural adjustment.

The zip code of the point of pickup determines both the appropriate payment and any rural adjustment.

CMS will furnish contractors electronic files that identify a zip code as rural or urban.

ZIP CODE DETERMINES APPLICABLE FEE SCHEDULE AMOUNT

The zip code of the point of pickup determines both the appropriate fee schedule amount and any rural adjustment. If the ambulance transport required a second or subsequent leg, then the zip code of the point of pickup of each leg will determine the applicable payment for each leg and any rural adjustment for each leg. The zip code of the point of pickup is required on a claim to determine the correct fee schedule amount and any rural adjustment.

CMS will furnish contractors with electronic files that identify a zip code as rural or urban.

Point of Pick-up zip code for Emergency Pick-up Outside of the United States

For coverage and limitations for ambulance services furnished in connection with foreign inpatient hospital services, refer to the Medicare Intermediary Manual (MIM) §3698.4, the Medicare Carriers Manual (MCM) §2312, and 42 Code of Federal Regulations (CFR) 411.9.

For point of pickup services outside of the United States or in United States territorial waters, suppliers and providers should report the point of pickup zip code according to the following:

- For ground or air transport outside of the United States to a drop off outside of the United States (in Canada or Mexico), use the closest United State zip code to the actual point of pickup.
- For water transport from the territorial waters of the United States to the United States, use the zip code of the port of entry.
- For ground transport from Canada or Mexico to the United States, use the zip code at the United States border at the point of entry into the United States.

- For air transport from areas outside of the United States to the United States, use the zip code at the border of the United States at the point of crossing.